

**DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS**

1115 WAIVER SURVEY

TECHNICAL ASSISTANCE GUIDE

**MEMBER RIGHTS
ROUTINE MEDICAL SURVEY
OF
PLAN NAME**

DATE OF SURVEY:

PLAN COPY

Issuance of this December 12, 2011 Technical Assistance Guide renders all other versions obsolete.

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MEMBER RIGHTS REQUIREMENTS

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Requirement MR-001: The Health Plan complies with requirements for a complaint/grievance system. (DMHC will examine a sufficient number of SPD member grievance files to ensure appropriate audit confidence level.)

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall include the following information:

- 13) Procedures for filing a grievance or appeal with Contractor, either orally or in writing, or over the phone, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the toll-free telephone number a Member can use to file a grievance or appeal, and the title, address, and telephone number of the person responsible for processing and resolving grievances and providing assistance completing the request. Information regarding the process shall include the requirements for timeframes to file a grievance or appeal, and timelines for the Contractor to acknowledge receipt of grievances, to resolve grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informing the Member that services previously authorized by the Contractor will continue while the grievance is being resolved.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

A. Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

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- A. Procedure to ensure timely acknowledgement, resolution, feedback to complainant. Provide oral notice of the resolution of an expedited review.
 - B. Procedure to ensure a Member is given reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and a toll-free number with TTY/TDD and interpreter capability.
 - C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.
 - D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.
 - E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's medical director.
 - G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:
 - 1) A denial based on lack of medical necessity;
 - 2) A grievance regarding denial of expedited resolutions of an appeal; and
 - 3) Any grievance or appeal involving clinical issues.
 - H. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the case of a grievance subject to expedited review, Contractor shall inform the Member of the limited time available to present evidence. Contractor shall also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a grievance.
3. Grievance Log and Quarterly Grievance Report
- A. Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
 - B. Contractor shall submit the quarterly grievance report for Medi-Cal Members only in the form that is required by and submitted to the DMHC as set forth in Title 28, CCR, Section 1300.68(f).
 - 1) In addition to the types or nature of grievances listed in Title 28, CCR, Section 1300.68(f)(2)(D), the report shall also include, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

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- 2) For the Medi-Cal category of the report, provide the following additional information on each grievance: timeliness of responding to the Member, geographic region, ethnicity, gender, primary language of the Member, and final outcome of the grievance.
4. Notice of Action
- B. If a Member receives a NOA (a formal letter informing a Member that a medical service has been denied, deferred, or modified), the Member has three options:
 - 1) Members have ninety (90) days from the date on the NOA to file an appeal of the NOA with their Plan. Members may request a State Fair Hearing regarding the NOA from the Department of Social Services (DSS) within ninety (90) days of the NOA.
 - 2) Members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.
 - 3) Members may file an appeal with their Plan regarding a NOA and request a State Fair Hearing regarding that NOA at the same time.
- C. During the appeal the Member must have a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Member must be given the opportunity before and during the appeals process to examine his/her case file, including medical records and any other documents and records considered during the appeals process.
- D. Member must be notified that the State must reach its decision for a standard State Fair Hearing within 90 days of the date of the request. For an expedited State Fair Hearing, the State must reach its decision with three (3) working days of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as outlined in APL 03-009, APL 04-006, and PL 09-006, in addition to any future DHCS APL or PL.
- E. Members can also file a grievance that is not about a NOA. Members must file a grievance within 180 days from the date the incident or action occurred which caused the member to be dissatisfied.

5. Member Appeal Process

Contractor shall implement and maintain an appeal process as described below to resolve Member appeals.

- A. Member, or a provider acting on behalf of a Member and with the Member's written consent, may file an appeal.
- B. Contractor must provide a Member notice, as expeditiously as the Member's health condition requires, within 45 days from the day Contractor receives the appeal. A Member notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum, must include:
 - 1) Member's right to request a State Fair Hearing;
 - 2) How to request a State Fair Hearing;
 - 3) Right to continue to receive benefits pending a State Fair Hearing; and
 - 4) How to request the continuation of benefits.
- C. Contractor may extend the timeframe to resolve an appeal by up to 14 calendar days if the Contractor shows that there is a need for additional information and how the delay is in the Member's interest.

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- D. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and Contractor reverses a decision to deny, limit, or delay services.
- E. Contractor must pay for disputed services if the Member received the disputed services while the appeal was pending.

7. Responsibilities in Expedited State Fair Hearings

Within two (2) working days of being notified by DHCS or the California Department of Social Services (CDSS) that a Member has filed a request for State Fair Hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate CDSS administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited State Fair Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent grievance resolution notice. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to CDSS along with copies of the original NOA and grievance resolution notice. One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited State Fair Hearing, shall be available by phone during the scheduled Hearing. During the State Fair Hearing process, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the Hearing is pending and Contractor reverses a decision to deny, limit, or delay services. Contractor must pay for disputed services if the Member received the disputed services while the Hearing was pending.

8. Parties to an Appeal or a State Fair Hearing

The parties to an appeal or a State Fair Hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased enrollee's estate.

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 14 – Member Grievance System

3. Grievance Log and Quarterly Grievance Report

- B. Contractor shall submit the quarterly grievance report for Medi-Cal Members only in the form that is required by and submitted to the DMHC as set forth in Title 28, CCR, Section 1300.68(f).
 - 1) In addition to the types or nature of grievances listed in Title 28, CCR, Section 1300.68(f)(2)(D), the report shall also include, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.
 - 2) For the Medi-Cal category of the report, provide the following additional information on each grievance: timeliness of responding to the Member, geographic region, ethnicity, gender, primary language of the Member, and final outcome of the grievance.

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DHCS GMC Boilerplate Contract, Exhibit A, Attachment 14 – Member Grievance System

3. Grievance Log and Quarterly Grievance Report
- B. Contractor shall submit quarterly grievance reports in the form that is set forth in 28 CCR 1300.68(f). The grievance report should include an explanation for each grievance that was not resolved within 30 calendar days of receipt of the grievance.
 - 1) In addition to the types or nature of grievances listed in 28 CCR 1300.68(f)(2)(D), the report shall also include, but not be limited to, untimely assignments to a Primary Care Provider, issues related to cultural sensitivity and linguistic access, difficulty with accessing specialists, and grievances related to out-of-network requests.
 - 2) For the Medi-Cal category of the report, provide the following additional information:
 - a) The total number of grievances received.
 - b) The average time it took to resolve grievances, which includes providing written notification to the Member.
 - c) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed grievances.

CA Health and Safety Code section 1367.01(j)

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code sections 1368(a)(1) and (4)

- (a) Every plan shall do all of the following:
- (1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.
 - (4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
 - (i) That the grievance has been received.
 - (ii) The date of receipt.
 - (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

CA Health and Safety Code sections 1368.01(a) and (b)

- (a) The grievance system shall require the plan to resolve grievances within 30 days.
- (b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not

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limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.

CA Health and Safety Code section 1368.02(b)

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online."

28 CCR 1300.68(a)

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request

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for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

- (2) "Complaint" is the same as "grievance."
- (3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
- (4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
 - (A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.
 - (B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

28 CCR 1300.68(b)(1), (3) through (8)

(b) The plan's grievance system shall include the following:

(1) Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.

(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to

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Section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.

(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsperson may be used.

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.

28 CCR 1300.68(d)(1) through (6), and (8)

(d) The plan shall respond to grievances as follows:

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

(3) The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in Subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee.

In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not

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medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage, and other relevant information upon which the plan relied in reaching its decision.

(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in Subsection (b).

28 CCR 1300.68(e)

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

- (1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: 1) the plan's internal grievance system; 2) the Department's consumer complaint process; 3) the Department's Independent Medical Review system; 4) an action filed or before a trial or appellate court; or 5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: 1) the Medicare review and appeal system; 2) the Medi-Cal fair hearing process; or 3) arbitration.
- (2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care and 4) complaints about access to care (including complaints about the waiting time for appointments), and 5) complaints about the quality of service, and 6) other issues.

28 CCR 1300.68(f)(1)

(f) Quarterly Reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

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28 CCR 1300.68.01(a) and (b)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

- (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
- (2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
- (3) Consideration by the plan of the enrollee's medical condition when determining the response time.
- (4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

(b) Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.

(c) The plan shall notify the Department before changing or modifying any benefit or services that relates to the urgent grievance submitted to the Department pursuant to subsection (b)(1)(A)

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of Section 1368 of the Act if the enrollee or the enrollee's representative objects to the change or modification.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or officer who has primary responsibility for the grievance system
- Manager of Member Services
- QM Director
- Director of Operations

DOCUMENT(S) TO BE REVIEWED

- Description of the grievance system, including how the Plan defines a grievance (appeal, complaint, inquiry, concern, grievance, etc.)
- Position description of the officer with primary responsibility for the grievance system
- Policy and procedure for generation and review of aggregated and tabulated grievances
- Grievance logs, including grievance logs from any subcontracting entity delegated the responsibility to maintain and resolve grievances
- Grievance forms
- Policies and procedures to maintain a system of aging of grievances pending and unresolved for 30 calendar days or more
- Policy and procedure to report quarterly to the DMHC and DHCS all grievances pending and unresolved for 30 calendar days or more.
- Policies and procedures for the processing of grievances, including processes, timeframes, criteria, staffing, etc.
- Policies and procedures for receiving and resolving urgent grievances
- Committee Minutes (Governing Body, QA, Public Policy, Grievance Committee, etc.), including grievance reports reviewed
- Reports and analysis by Plan's grievance officer regarding emergent patterns of grievances for most recent 6-12 month period.

MR-001 - Key Element 1:

1. The Plan has a complaint and grievance system for the receipt, review, and resolution of grievances.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services, Item 4 (D); Attachment 14 – Member Grievance System, Item (2)(B) though (E); Item 3 (A) and (B); CA Health and Safety Code section 1368(a)(1); 28 CCR 1300.68(b)(1), (3) through (8); 28 CCR 1300.68(d)(6); 28 CCR 1300.68.01(a) and (b)

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Assessment Questions	Yes	No	N/A
Does the Plan have a written grievance system that describes the following:			
1.1 Does the Plan maintain a toll-free number and local number for filing grievances in each service area?			
1.2 Are grievance forms and procedures available at contract facilities and provider offices?			
1.3 Does the Plan inform members and providers of grievance procedures?			
1.4 Does the grievance system ensure that a Member is given reasonable assistance in completing forms and other procedure steps (including but not limited to providing interpreter services, providing a toll-free number with TTY/TDD and interpreter capability, etc.)?			
1.5 Does the grievance system consider the linguistic and cultural needs of the enrollee population and the needs of enrollees with disabilities?			
1.6 Does the grievance system include a policy that prohibits discrimination against a member for filing a grievance?			
1.7 Does the Plan's grievance system address expedited grievances?			
1.8 Does the Plan's grievance system include the criteria for cases to be considered expedited (severe pain, potential loss of life, limb, or major bodily function)?			
1.9 Does the Plan's grievance system provide the mechanisms and staff for receipt of urgent grievances 24 hours per day, 7 days per week?			
1.10 Does the grievance system provide for prompt review of grievances by the appropriate level of management/supervisory staff and/or clinical staff responsible for the service and/or quality of care which is the subject of the grievance?			
1.11 Does the Plan keep a written record of each grievance, including date, identification of individual recording the grievance, description of grievance, and disposition?			
1.12 Does the Plan's grievance system provide for the maintenance of copies of grievances and responses for five years, which shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Plan relied in reaching its decision?			
1.13 Does the grievance system description include oversight of delegated entities (as applicable) and procedures for such oversight?			
1.14 Does the grievance system include procedures for the systematic aggregation and analysis of the grievance data and use for quality improvement?			

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Assessment Questions	Yes	No	N/A
1.15 Has the Plan Officer designated by the Plan as having responsibility for the grievance system conducted monitoring activities?			
1.16 Are tabulated grievances reviewed by the Governing Body, and officer of the Plan or designee, with documentation of the review?			
1.17 Does the Plan submit quarterly grievance reports to DMHC and DHCS, ensuring that the DHCS quarterly reports include the following additional data elements? 1) timely assignments to a provider 2) issues related to cultural and linguistic sensitivity 3) difficulty accessing specialists 4) grievances related to out of network requests 5) timeliness of responding to the member 6) geographic region 7) ethnicity, gender 8) primary language of the member, and 9) final outcome of the grievance			

MR-001 - Key Element 2:

- 2. The Plan acknowledges and responds to grievances in a timely manner. (Compliance verified by conducting review of complaint and grievance files.)**
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 14 – Member Grievance System, Item 1; Item 2 (A); Item 4 (D); Item 5 (B); CA Health and Safety Code section 1368(a)(4); 28 CCR 1300.68 (a); 28 CCR 1300.68(b)(3); 28 CCR 1300.68(d)(1), (3); 28 CCR 1300.68.01(a) and (b)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan consistently acknowledge grievances and appeals in writing <u>within five (5) calendar days</u> of receipt (except as noted in 28 CCR 1300.68(d)(8))? (Grievance/Appeals Worksheet #9)			
2.2 Does the Plan consistently resolve non-urgent grievances (all levels) and send its written resolution to the grievant <u>within 30 calendar days</u> (or <u>within 45 days</u> for DHCS SPD member <u>appeals</u>) of Plan receipt of the grievance? (Grievance/Appeals Worksheet #17)			
2.3 When determining the grievance resolution timeframe (for both expedited and standard grievances), does the Plan take into account the member's condition and resolve the grievance as expeditiously as the member's health condition requires? (Grievance/Appeals Worksheet #7)			

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Assessment Questions	Yes	No	N/A
2.4 If the Plan cannot resolve the grievance <u>within 30 calendar days</u> , does the Plan report the grievance as pending or unresolved in its quarterly report to the Department?			
2.5 Does the Plan notify the member that the State must reach its decision for a State Fair Hearing <u>within 90 days</u> of the date of request? (Grievance/Appeals Worksheet #25)			
2.6 Does the Plan consistently provide a written statement to the complainant on the disposition or pending status of the urgent grievance within <u>three (3) working days</u> from receipt? (Grievance/Appeals Worksheet #9)			
2.7 Does the Plan make a reasonable effort to provide oral notice of the resolution of expedited and/or urgent grievances and/or appeals? (Grievance/Appeals Worksheet #18)			

MR-001 - Key Element 3:

3. The Plan's responses to grievances contain all required information. (Compliance verified by conducting review of complaint and grievance files.)
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 14 – Member Grievance System, Item 2 (B) and Item 7; CA Health and Safety Code section 1368(a)(4); CA Health and Safety Code section 1368.02(b); 28 CCR 1300.68(a); 28 CCR 1300.68(d)(4) and (5)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan's written acknowledgment advise the grievant of the date the Plan received the grievance? (Grievance/Appeals Worksheet #10)			
3.2 Does the Plan's written acknowledgment provide the name, address, and telephone number of the Plan representative who may be contacted about the grievance? (Grievance/Appeals Worksheet #11)			
3.3 Does the Plan's written acknowledgment display the Plan's telephone number, the Department's telephone number, TDD line, and Internet address in 12-point boldface type with the required statement contained in subsection (b) of Section 1368.02 of the Act? (Grievance/Appeals Worksheet #12)			
3.4 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does each response contain a <u>clear and concise</u> explanation of the Plan's decision? (Grievance/Appeals Worksheet #23)			

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Assessment Questions	Yes	No	N/A
3.5 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does each response contain the <u>criteria, clinical guidelines, or medical policies</u> used in reaching the determination? (Grievance/Appeals Worksheet #22)			
3.6 For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is <u>not medically necessary</u> , does each response contain <u>notification</u> that the determination may be considered by the Department's <u>independent medical review</u> system and provide an application for IMR? (Grievance/Appeals Worksheet #26)			
3.7 For DHCS SPD members, does the response include the member's right to a <u>State Fair Hearing</u> , how to request a State Fair Hearing, the right to continue to receive benefits pending the State Fair Hearing, and how to request the continuation of benefits? (Grievance/Appeals Worksheet #25)			
3.8 Does the Plan's written response display the Plan's telephone number, the Department's telephone number, TDD line, and Internet address in 12-point boldface type with the required statement contained in subsection (b) of Section 1368.02 of the Act? (Grievance/Appeals Worksheet #20)			
3.9 For grievances involving a determination that the requested service is <u>not a covered benefit</u> , does each response contain the <u>specific provision</u> in the contract, <u>EOC</u> or member handbook that excludes the services (either by identifying the document and page where the provision is found, by directing the grievant to the applicable section of the contract or by providing a copy of the provision)? (Grievance/Appeals Worksheet #21)			
3.10 For grievances involving a determination that the requested service is <u>not a covered benefit</u> , does each response contain <u>clear and concise</u> language that explains how the exclusion applied to the specific health care service or benefit requested by the enrollee? (Grievance/Appeals Worksheet #23)			
3.11 For grievances involving a determination that the requested service is <u>not a covered benefit</u> , does each response contain <u>notice</u> that if the <u>enrollee believes</u> the decision was denied on the grounds that it was <u>not medically necessary</u> , the Department should be contacted to determine whether the decision is eligible for an <u>independent medical review</u> ? (Grievance/Appeals Worksheet #26)			

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Assessment Questions	Yes	No	N/A
3.12 Do Plan responses address the language and disability needs of enrollees by providing assistance (including translation and interpretation services, access to telephone relay services, and other devices to aid disabled enrollees)? (Grievance/Appeals Worksheet #24)			

MR-001 - Key Element 4:

- 4. The Plan's grievance system meets defined requirements. (Compliance for some verified by conducting review of complaint and grievance files.)**
DHCS Two-Plan and GMC Boilerplate Contract, Exhibit A, Attachment 14 – Member Grievance System, Item 2 (D), (G), and (H); Item 4 (C); Item 5 (D); Item 7; CA Health and Safety Code section 1368(a)(1)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan ensure that members are given a reasonable opportunity to present (in writing or in person) information to support their grievance?			
4.2 Does the Plan authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires?			
4.3 For grievances involving medical necessity or other clinical issues, does the Plan appropriately refer the grievance for review to a licensed healthcare professional competent to evaluate the clinical issues of the grievance? (Grievance/Appeals Worksheet #19)			
4.4 Does the Plan ensure that the person making the final decision to resolve the grievance has not participated in any prior decisions related to the grievance?			
4.5 For grievances involving contested claims, does the Plan appropriately refer the claim for review to a licensed and competent health care provider to evaluate the clinical issues of the appealed claim, as applicable? (Grievance/Appeals Worksheet #19)			
4.6 Does the Plan's grievance system allow a member to file an expedited appeal either orally or in writing with no additional member follow-up required?			

End of Requirement MR-001: The Health Plan complies with requirements for a complaint/grievance system. (DMHC will examine a sufficient number of SPD member grievance files to ensure appropriate audit confidence level.)

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Requirement MR-002: The Health Plan complies with PCP selection and assignment requirements.

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services

6. Primary Care Provider Selection

- A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician (PCP).
 - 1) Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first 30 calendar days of enrollment.
 - 2) Contractor may allow Members to select a clinic that provides primary care.
 - 3) If the Contractor's provider network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with Title 22 CCR Section 53853(a)(4).
 - 4) Contractor shall provide a mechanism for SPD beneficiaries to select a specialist or clinic that meets DHCS subcontracting requirements as stated in Attachment 6 of this contract as a Primary Care Physician if the specialist or clinic agrees to serve as a primary care provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W & I Code Section 14182 (b)(11).
 - 5) Contractor shall ensure that Members are allowed to change a Primary Care Physician, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's network of providers.
- B. Contractor shall disclose to effected Members any reasons that their selection or change in PCP could not be made.
- C. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.
- D. Contractor shall ensure that Members may choose Traditional and Safety Net Providers as their Primary Care Provider.

7. Primary Care Provider Assignment

- A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Primary Care Providers. If, at any time, a Member notifies the Contractor of a Primary Care Provider or Subcontracting Health Plan choice, such choice shall override the Member Assignment to a Primary Care Provider or Subcontracting Health Plan.

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- B. If a SPD beneficiary does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing provider relationships for the purpose of Primary Care Provider assignment, including a specialist or clinic if a SPD beneficiary indicates a preference for either. Contractor shall comply with all Federal and State privacy laws in the provision and use of this data.
- C. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the provider within 10 calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.
- D. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit E, Attachment 1 – Definitions

- 103. Safety-Net Provider** means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.
- 104. Traditional Provider** means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

CA Health and Safety Code sections 1367.69(a) and (b)

(a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

CA Health and Safety Code section 1373.3

An enrollee shall not be prohibited from selecting as a primary care physician any available primary care physician who contracts with the plan in the service area where the enrollee lives or works. This section shall apply to any plan contract issued, amended, renewed, or delivered on or after January 1, 1996.

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INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- Individual responsible for ensuring PCP selection for new enrollees
- Information Technology Manager or staff assigned to conduct data analysis for PCP assignment
- Manager of Member Services

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures related to primary care provider selection and assignment, including:
 - Procedures for PCP assignment, including data analysis to ensure appropriate assignment, timelines, etc.
 - Procedures for PCP selection, including PCP and member notifications and timelines
 - Procedures for provider contract termination and the associated member re-assignment
- Sample member communications when the member's PCP selection could not be made
- Sample member and PCP communications for PCP selection and assignment
- Provide a list of providers and provider groups terminated in the previous 24 months.
- Provide a list of the enrollees who requested a transfer of a PCP

MR-002 - Key Element 1:

1. The Plan has developed and implemented procedures ensuring that each new member has an appropriate and available Primary Care Physician.
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services, Item 6 and Item 7; CA Health and Safety Code section 1367.69(a); CA Health and Safety Code section 1373.3

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have procedures in place that provide SPD enrollees the opportunity to select a PCP within 30 calendar days of enrollment?			
1.2 Do the Plan's procedures ensure that members with an established relationship with a contracted provider are assigned that provider without disruption in care?			

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Assessment Questions	Yes	No	N/A
1.3 Do the Plan's procedures allow each new member to select a primary care clinic, certified nurse practitioner, certified nurse midwife, or physician assistant – if included in the Plan's network – to provide primary care services?			
1.4 Do the Plan's procedures allow SPD enrollees to select a specialist or clinic as a primary care provider, if requirements are met?			
1.5 Do the Plan's procedures allow SPD enrollees to choose Traditional and Safety-Net providers as primary care providers?			
1.6 Does the Plan ensure that members are allowed to change their Primary Care Provider by selecting another Primary Care Provider from the Plan's network of providers?			
1.7 Can the Plan demonstrate that the reasons a member's PCP selection or change could not be made were disclosed to the member?			
1.8 Can the Plan demonstrate that procedures are in place to ensure the orderly transfer of care when a physician's contract is terminated or not renewed?			
1.9 If a member does not select a PCP within 30 calendar days of enrollment, does the Plan use utilization or other data to determine existing provider relationships for the purpose of assigning a PCP?			
1.10 Can the Plan demonstrate that members have been assigned a PCP if they did not select one within the specified timeframe?			
1.11 Can the Plan demonstrate that they notified the PCP within 10 calendar days of assignment/selection?			

End of Requirement MR-002: The Health Plan complies with PCP selection and assignment requirements

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Requirement MR-003: The Health Plan ensures that interpreter services and member-informing materials are available in identified threshold languages.

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access & Availability

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements stipulated below.

B. Linguistic Capability of Employees

Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

F. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

DHCS Two-Plan Boilerplate Contract, Exhibit A, Attachment 9 – Access & Availability

14. Linguistic Services

- A. Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.
- B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:
 - 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
 - 2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

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- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD)
TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general
- C. Contractor shall provide translated materials to the following population groups within its Service Area as determined by DHCS:
 - 1) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.
 - 2) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.
- D. Key points of contact include:
 - 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
 - 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

DHCS Boilerplate GMC Contract, Exhibit A, Attachment 9 – Access & Availability

14. Linguistic Services

- A. Contractor shall ensure equal access to health care services for limited English proficient Members through provision of high quality interpreter and linguistic services.
- B. Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Subprovision E of this Provision, either through interpreters, telephone language services, or any electronic communication options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.
- C. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:
 - 1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to all Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
 - 2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.
 - 3) Referrals to culturally and linguistically appropriate community service programs.
 - 4) Telecommunications Device for the Deaf (TDD)

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TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.

- 5) Telecommunications Relay Service (711)
The 711-telephone number is the Telecommunications Information Relay Service that connects a hearing impaired person with a specially trained operator who acts as an intermediary, relaying conversations between hearing persons and persons using a TDD/TTY device.
- D. Contractor shall provide translated materials to the following population groups within its Service Area as determined by DHCS:
 - 1) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.
 - 2) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.
- E. Key points of contact include:
 - 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.
 - 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services

1. Member Rights and Responsibilities
- A. Member Rights and Responsibilities
Contractor shall develop, implement, and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, providers, and, upon request, potential members.
 - 1) Contractor's written policies regarding Member rights shall include the following:
 - (f) To receive oral interpretation services for their language
4. Written Member Information
- C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.
 - 1) Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.

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CA Health and Safety Code sections 1367.04(b)(1)(A), (b)(4), and (b)(5)

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (1). The regulations shall include the following:

(1) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(ii) A health care service plan with an enrollment of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment as required by this subdivision and any additional languages when 1 percent or 6,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(iii) A health care service plan with an enrollment of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(4) Requirements for individual enrollee access to interpretation services.

(5) Standards to ensure the quality and timeliness of oral interpretation services provided by health care service plans.

CA Health and Safety Code section 1367.04(h)(1)

(h)(1) Except for contracts with the State Department of Health Services Medi-Cal program, the standards developed under this section shall be considered the minimum required for compliance.

(2) The regulations shall provide that a health plan is in compliance if the plan is required to meet the same or similar standards by the Medi-Cal program, either by contract or state law, if

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the standards provide as much access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the standards of the regulations established pursuant to this section, and the department determines that the health care service plan is in compliance with the standards required by the Medi-Cal program. To meet this requirement, the department shall not be required to perform individual audits. The department shall, to the extent feasible, rely on audits, reports, or other oversight and enforcement methods used by the State Department of Health Services.

(3) The determination pursuant to paragraph (2) shall only apply to the enrollees covered by the Medi-Cal program standards. A health care service plan subject to paragraph (2) shall comply with the standards established by this section with regard to enrollees not covered by the Medi-Cal program.

28 CCR 1300.67.04(c)(2)(F), (G), and (H)

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

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(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent, and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact.

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

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- (i) A documented and demonstrated proficiency in both English and the other language;
- (ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and
- (iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of QM Program and/or Executive with overall responsibility for the Plan's LA Program
- Manager of Member / Customer Services
- Director or Manager of Provider Networks or Provider Contracting
- Cultural and Linguistic Coordinator / Language Assistance Program Coordinator
- Member / Customer Service staff
- Plan Manager responsible for oversight of delegated programs

DOCUMENT(S) TO BE REVIEWED

- Plan's Language Assistance (LA) Program and LA policies & procedures
- Workflow / process map / algorithm for accessing interpreter services by point of contact.
- A list of all translated vital documents, and samples of at least 3 of the following documents:
 - Applications
 - Consent forms
 - Letters to enrollees regarding eligibility and participation criteria
 - Notices pertaining to denial, reduction, modification, or termination of services and benefits and the right to file a grievance or appeal
 - Notices advising limited English proficiency (LEP) enrollees of the availability of free LA services and other outreach materials provided to enrollees
 - Claims processing documents that require a response from the enrollee
- Plan's Language Survey Report results
- Internal interpretation/translation staff proficiency assessment tool
- If the Plan has contracted with vendor, the vendor assessment tool and/or vendor contract language that establishes the proficiency of the vendor's staff providing LA services
- Sample of completed staff proficiency assessments
- Evidence of qualifications for health plan staff utilized for interpretation/translation services
- Log(s) or report(s) of LA services provided by the Plan (directly or through vendor contracts), including request date and time and LA service delivery date and time

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- Log(s) or report(s) of LA services accessed through a provider's office
- Report of complaints and grievances related to LA services
- Committee minutes of the Quality Management/Oversight Committee reviewing the Plan's LA Program
- Delegation policies and procedures, including those detailing the processes for LA services delegation and continued oversight of delegated entities
- Documentation that the Plan conducts a periodic audit of delegated activities and requires a corrective action plan for deficiencies identified with documentation of appropriate follow-up
- Plan's Web site (identifying all areas related to LA services, including but not limited to: notice of availability, translated vital documents, grievance forms and information, etc.)

MR-003 - Key Element 1:

1. The Plan demonstrates that interpreter services and member-informing materials are available in identified threshold languages.
DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 9 – Access and Availability, Item 13; and 14; Attachment 13 – Member Services, Item 1 (A) and Item 4 (C); CA Health and Safety Code sections 1367.04(b)(1)(a), (b)(4), and (b)(5); CA Health and Safety Code section 1367.04(h)(1); 28 CCR 1300.67.04 (c)(2)(F) through (G);

Assessment Questions	Yes	No	N/A
1.1 Can the Plan demonstrate that it has processes in place to inform SPD enrollees and providers of the availability of translation services for written materials for address both medical/clinical and non-medical/administrative points of contact?			
1.2 Can the Plan demonstrate that it has processes in place to inform SPD enrollees and providers of the availability of interpretation services for address both medical/clinical and non-medical/administrative points of contact?			
1.3 Can the Plan demonstrate how it provides or arranges for translation of vital documents at no charge to enrollees?			
1.4 Does the Plan provide timely translation of vital documents to the enrollee?			
1.5 Does the Plan ensure that the translation is accurate?			
1.6 Can the Plan demonstrate how it provides or arranges for interpretation services at no cost to the enrollee at all points of contact, including medical/clinical points of contact (such as Physician's office, ancillary services, pharmacies, facilities, hospitals, nurse advice lines, etc.)?			
1.7 Can the Plan demonstrate how it provides or arranges for interpretation services at no cost to the enrollee at all points of contact, including non-medical/administrative points of contact (such as member services, orientations, appointment scheduling)?			

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Assessment Questions	Yes	No	N/A
1.8 Do the Plan's resources (bilingual staff or provider, contracted interpreter, telephonic Language Assistance, video-conferencing supported Language Assistance services, etc.) provide timely interpretation services at all <u>medical</u> and <u>non-medical</u> points of contact?			
1.9 Is the range of interpretation services offered appropriate for the particular point of contact (medical/clinical and non-medical/administrative)?			
1.10 Does the Plan ensure that enrollees have adequate access for after hours for clinical points of contact (i.e. urgent or emergency)?			
1.11 Has the Plan defined standards to ensure the quality and accuracy of translation and interpretation services and do those standards include language proficiency, education and training in ethics, conduct and confidentiality?			
1.12 Do the Plan's processes and standards ensure the proficiency of individuals or groups (both <u>internal Plan staff</u> as well as <u>contract/vendor staff</u>) providing translation and interpretation services?			
1.13 Does the Plan 'test' or 'validate the quality' of services provided by individuals or groups providing translation and interpretation services?			

End of Requirement MR-003: The Health Plan ensures that interpreter services and member-informing materials are available in identified threshold languages.

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Requirement MR-004: The Health Plan ensures the ability to provide communication access to SPDs in alternative formats or through other methods that ensure communication.

STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services

1. Member Rights and Responsibilities
- A. Member Rights and Responsibilities
Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, providers, and, upon request, potential members.
 - 1) Contractor's written policies regarding Member rights shall include the following:
 - (o) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
4. Written Member Information
- C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions.
 - 1) Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
 - 2) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of the QI Program
- Director of Member / Customer Service

DOCUMENT(S) TO BE REVIEWED

- Enrollee/Member handbook
- Evidence of Coverage (EOC)

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- Policies and procedures regarding member access to communications in alternative formats
- Sample enrollee communications regarding the availability of communications in alternative formats
- Sample enrollee communications in alternative format

MR-004 - Key Element 1:

1. The Plan provides access to communications in alternative formats or through other methods to ensure communication with SPD enrollees.

DHCS Two-Plan and GMC Boilerplate Contracts, Exhibit A, Attachment 13 – Member Services, Item (1) and Item (4)

Assessment Questions	Yes	No	N/A
1.1 Do the Plan's Member Rights policies reference a requirement to provide written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request?			
1.2 Do the Plan's policies specify the member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand?			
1.3 Can the Plan demonstrate that it provides written member informing materials in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested?			
1.4 Has the Plan established policies and procedures to enable members to make a standing request to receive all informing materials in a specified alternative format?			
1.5 Does the Plan have Telecommunications Device for the Deaf (TDD)?			
1.6 Does the Plan have staff trained and capable of using the TDD(s)?			
1.7 Does the Plan inform deaf Plan members of the availability of TDD (or signers, if relevant)?			

End of Requirement MR-004: The Health Plan ensures the ability to provide communication access to SPDs in alternative formats or through other methods that ensure communication.